

Underservice workgroup, Complex Care Committee, MAPOC
Underservice monitoring recommendation report
7.20.14

Charge: The MAPOC Complex Care Committee is charged with advising the CT Department of Social Services on development of a pilot health neighborhood program of coordinated care for people eligible for both Medicare and Medicaid. Prompted by concerns that shared savings incentives in the program could have the unintended consequence of encouraging underservice, the committee convened this workgroup to make recommendations for developing an effective system to monitor for inappropriate underservice.

Members:

Claudio Gualtieri -- AARP – Workgroup Co-Chair

Ellen Andrews -- CT Health Policy Project – Workgroup Co-Chair

Matt Katz -- CT State Medical Society

Sheldon Toubman -- New Haven Legal Assistance

Karyl Lee Hall -- CT Legal Rights Project

Margaret Flinter-- Community Health Center, Inc.

Rob Aseltine – UConn

Deb Polun – Community Health Association of CT

Robert Smanik -- Day Kimball Hospital

Steve Frayne -- CT Hospital Association

Margaret Murphy – Center for Medicare Advocacy

Bonnie Roswig – Center for Children’s Advocacy

Daniela Giordano – NAMI - CT

Melinda Montovani – Brain Injury Association of CT

Patricia Kelmar – CT Center for Patient Safety

Mark Schaefer – SIM

Bill Halsey – Department of Social Services

Julie Evans Starr -- CT Commission on Aging

Jill Benson -- CHR

Molly Gavin – CT Community Care, Inc.

Quincy Abbot -- ARC CT

Liz Collins – New England Homecare

Doug Wyse -- AARP

Meetings:

The committee met in-person twice (March 25th and June 27th) and once in an online meeting (June 11th). The committee reviewed resources (below, posted online), collected proposals, and drafted recommendations in the online meeting. The committee used a survey of members to select and categorize recommendations. The

recommendations were finalized by consensus at our last in-person meeting and later by email.

Resources:

Webinar with Crystal Run Healthcare ACO (NY)

Online survey to collect broad input from consumers, advocates, administrators and providers

Literature review

Interviews with NCQA and nationally accredited ACOs

Research other states' underservice monitoring provisions

Questions remaining:

- Feasibility -- What can be done now? What systems need to be developed to reach the rest of the recommendations? What will be done to minimize the burden on providers and EMR requirement? Timeliness of data to ensure problems are identified before there is harm to people? How will denied claims be tracked? Types of care within a CPT code that may be underservice? How will non-payment treatment methods be included (i.e. samples)?
- Costs – What resources will DSS devote to underservice monitoring? Who will be responsible for analysis?
- Relative responsibilities -- What will be expected of neighborhoods vs. DSS/contractor in monitoring? Will there be audits of neighborhood quality systems, including underservice? How will contracts and financial relationships be monitored for underservice incentives? How will networks be developed – by the neighborhood with contracts or measure access across all Medicare and Medicaid providers?
- Resolution process – How will potential underservice concerns be confirmed and resolved after they are identified? How will we help providers improve? How will we help consumers who've been underserved? How will we identify when consumers' actions led to underservice (i.e. stopped taking medication, refused treatment)? How to monitor for rising risk scores due to more health problems identified to treat? How and who will address consumer complaints and grievances?
- Ongoing education about underservice/overtreatment for both consumers and providers – How to ensure that marketing protections do not delay getting information to consumers?
- Guidelines – How will care guidelines be identified or developed against which to measure care? What happens in cases of overlap or conflicting guidance between sources and for people with multiple conditions?
- Care plans – There was a lot of discussion about standards for care plans. Who signs, how are they developed, ensuring they aren't just a report from an EMR but track back to consumer goals, ensuring consumers understand and agree with everything in them, specificity to allow measurement of under service (i.e.

- specific levels of treatment planned, with sources), ensuring that the care planning process does not delay care
- Penalties
 - Learning – How will monitoring be used to identify trends, outliers that could indicate opportunities or widespread challenges that may need a policy or systemic solution?
 - Relationship between Medicare and Medicaid – What pays for what? How are service levels approved? Which networks are available for which services? Transitioning between payment sources during a course of treatment should not affect care levels or sources.

Recommended next steps:

- Create a workgroup to advise the program on effective care plans and ensuring they are used effectively and revised when needed
- Create workgroups to resolve areas of questions above
- Assess data availability, what needs to be developed
- Delve deeper into
 - how to identify when consumers actions' led to underservice, reasons and potential policy solutions
 - consumer and provider perspectives on the recommendation -- Ensure people with a predominant condition, such as mental health, intellectual disability, brain injury, etc. who seek care for other health conditions are treated for those conditions without looking 'through their primary condition lens.'